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Secretary of State

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PROFIT CORPORATION ANNUAL REPORT

1999

FLORIDA DEPARTMENT OF STATE
Katherine Harris
Secretary of State
DIVISION OF CORPORATIONS

DOCUMENT # P94000035258

1. Corporation Name
SOUTHEAST VOLUSIA COUNTY MEDICAL ASSOICATES, P.A

Principal Place of Business
501 LIVE OAK
NEW SMYRNA BEACH FL 32168

Mailing Address 350 N. CAUSEWAY
~~P.O. BOX 450~~ % BELOTE CPAS
NEW SMYRNA BEACH FL ~~32170-0450~~
32169-5233

DO NOT WRITE IN THIS SPACE

2. Principal Place of Business	2a. Mailing Address	3. Date Incorporated or Qualifed	
21	26 350 NORTH CAUSEWAY	05/06/1994	
Suite, Apt. #, etc.	Suite, Apt. #, etc.	4. FEI Number	☐ Applied For
22	27 % BELOTE CPAS	59-3253271	☐ Not Applicable
City & State	City & State	5. Certifcate of Status Desired ☐	$8.75 Additional Fee Required
23	28 NEW SMYRNA BEACH	6. Election Campaign Financing Trust Fund Contribution ☐	$5.00 May Be Added to Fees
Zip / Country	Zip / Country	8. This corporation owes the current year Intangible Personal Property Tax.	☒ Yes ☐ No
24 / 25	29 32169-5233 30 VOLUSIA		

9. Name and Address of Current Registered Agent

TOUB, FRANK W
501 LIVE OAK
NEW SMYRNA BEACH FL 32168

10. Name and Address of New Registered Agent

81 Name

82 Street Address (P.O. Box Number is Not Acceptable)

83

84 City FL 85 Zip Code

11. Pursuant to the provisions of Sections 607.0502 and 607.1508, Florida Statutes, the above-named corporation submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida. Such change was authorized by the corporation's board of directors. I hereby accept the appointment as registered agent. I am familiar with, and accept the obligations of, Section 607.0505, Florida Statutes.

SIGNATURE _____ DATE
Signature, typed or printed name of registered agent and title if applicable. (NOTE: Registered Agent signature required when reinstating)

12. OFFICERS AND DIRECTORS			13. ADDITIONS/CHANGES TO OFFICERS AND DIRECTORS IN 12	
TITLE	D	☐ DELETE	1.1 TITLE	☐ Change ☐ Addition
NAME	TOUB, FRANK W M.D.		1.2 NAME	
STREET ADDRESS	501 LIVE OAK		1.3 STREET ADDRESS	
CITY-ST-ZIP	NEW SMYRNA BEACH FL 32168		1.4 CITY-ST-ZIP	
TITLE	T	☐ DELETE	2.1 TITLE	☐ Change ☐ Addition
NAME	SCHILDECKER, CHARLES W MD		2.2 NAME	
STREET ADDRESS	401 DOWNING		2.3 STREET ADDRESS	
CITY-ST-ZIP	NEW SMYRNA BEACH FL 32168		2.4 CITY-ST-ZIP	
TITLE	VP	☐ DELETE	3.1 TITLE	☐ Change ☐ Addition
NAME	ROSEMUND, R. ERIC MD		3.2 NAME	
STREET ADDRESS	420 PALMETTO		3.3 STREET ADDRESS	
CITY-ST-ZIP	NEW SMYRNA BEACH FL 32168		3.4 CITY-ST-ZIP	
TITLE	P	☐ DELETE	4.1 TITLE	☐ Change ☐ Addition
NAME	CREWE, BRUCE H MD		4.2 NAME	
STREET ADDRESS	812 W, INDIAN RIVER BLVD.		4.3 STREET ADDRESS	
CITY-ST-ZIP	EDGEWATER FL 32132		4.4 CITY-ST-ZIP	
TITLE		☐ DELETE	5.1 TITLE	☐ Change ☐ Addition
NAME			5.2 NAME	
STREET ADDRESS			5.3 STREET ADDRESS	
CITY-ST-ZIP			5.4 CITY-ST-ZIP	
TITLE		☐ DELETE	6.1 TITLE	☐ Change ☐ Addition
NAME			6.2 NAME	
STREET ADDRESS			6.3 STREET ADDRESS	
CITY-ST-ZIP			6.4 CITY-ST-ZIP	

CR2E034 (11/98)

14. I hereby certify that the information supplied with this filing does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I further certify that the information indicated on this annual report or supplemental annual report is true and accurate and that my signature shall have the same legal effect as if made under oath; that I am an officer or director of the corporation or the receiver or trustee empowered to execute this report as required by Chapter 607, Florida Statutes; and that my name appears in Block 12 or Block 13 if changed, or on an attachment with an address, with all other like empowered.

SIGNATURE: SIGNATURE REQUIRED
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #